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LETTERS

MARKETS IN HEALTH CARE

Markets will never work

Gubb would promote choice and "efficiency" in the NHS by increasing "market concentration,"[1] yet in a system starved of resources for so long, many patients would prefer to be spared the choice.

The most obvious drawbacks of introducing a competitive market into the NHS are:

- The obscene spectacle of a rich country overproviding—and then presumably culling—services and expensively trained staff to drive competition when most of the world is starved of basic health care
- The marginalisation of people with chronic disease—the main "consumers" of health care in an ageing post-industrial society—as financial liabilities
- The inevitable rigging of evidence of "market efficiency"—anyone can make independent providers look more efficient when they can cherry pick their patients and avoid staff training costs
- The demoralising effect on staff of a system that discourages collaboration and assumes that cash alone will motivate them to work harder for patients. Anyone who thinks financial incentives are the best way to cost effective health care should compare Cuba with the United States.

Leaving these drawbacks aside, the prospects of either a market led or a centrally directed service being made to work efficiently by politically driven NHS management look remote.

In emergency care the only way to improve "productivity" is to save on staff costs—either clinical or administrative. In a real market administrative staff are indispensable for billing patients and insurers, while in a centralised "internal market" system ever more are needed to produce and "present" data to demonstrate compliance with "best practice" targets. In both systems, of course, non-clinical staff decide whose jobs are to go when cuts are imposed—check out the prediction.

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1 Gubb J. Will a market deliver quality and efficiency in health care better than central planning ever could? Yes. *BMJ* 2010;340:c1297. (10 March.)

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Solidarity to achieve equality

The debate on the role of the market in health care continues.[1 2] In 2008 the World Health Organization published evidence of the damaging effects of making health care a commodity.[3] Three inequalities prevent the market from being able to ensure equitable health care:

- The social inequality in health: people who belong to the lowest income groups or who have the poorest education become ill most often and need most care[3]
- The inequality in health needs, or the skewed risk distribution. In Belgium, for example, 10% of the population, mostly elderly and chronically ill patients, consume 70% of all healthcare expenses[4]; the ageing of the population will increase this lopsided demand for health care
- The inequality in access to healthcare facilities, the so called inverse care law.[5]

Solidarity is therefore needed to make health care accessible to all. It means transferring resources from people who are "wealthy and healthy" to those who are "infirm and in want." On the income side, the strong should bear the heaviest burdens. On the expenses side, means ought to be distributed according to greatest need and not, as in the market, to those who can pay most (purchasing power) to gain most (profit). If health care is a basic right, it must not be a commodity. Solidarity, not profitability, is the best insurance policy.

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Competing interests: None declared.

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Benefits of cooperation

The ideology behind the BMA's campaign on the wasteful commercialisation of the NHS is hard to understand.[1] The NHS has been working and contracting with the commercial sector for decades. For example, although most of the country's care homes are in the private sector, over 70% of Bupa's 19 000 care beds are funded by the NHS or local authorities, and this arrangement has incited little controversy. Does the BMA now wish to bring them all back into public ownership?[1] If not, what is the ideological difference between social care/nursing and primary and secondary care?

Healthcare systems worldwide are facing huge challenges, so it makes sense to pool experience and work together. People working in private health care are just as dedicated to helping their patients live longer, healthier lives as are those in the public sector.

Many of the issues outlined by Meldrum are related more to poor contracting than to fundamental weaknesses in the commercial sector. Private companies will provide the services they are contracted for because if they don't they risk losing the contract. As for cost or, more importantly, value, they do not fear competition and, if they can't beat a competing bid from the public sector, they don't deserve the contract. In fact, the biggest issue facing all those tendering for NHS contracts is the highly bureaucratic tendering process, which is expensive for everyone concerned, probably including the NHS in the long run.

We should be less ideological and more pragmatic, and aim to work together to tackle waste, inefficiency, and the challenges ahead.

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1 Meldrum H. Stop this wasteful commercialisation of the NHS. *BMJ* 2010;340:c1357. (10 March.)

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ASPIRIN IN PRIMARY PREVENTION

Evidence is lacking

Sever states: "The evidence supports such use in those with an estimated 10 year risk of a cardiovascular event of ›20%."[1] I am not aware of any prospective, placebo controlled randomised controlled trial (RCT) designed to test this hypothesis. A recent British Hypertension Society publication references a subgroup analysis of the HOT trial published in 2002.[2] This would be regarded by many as unreliable evidence.

A 2008 Cochrane review did not recommend aspirin for primary prevention in patients with raised blood pressure because the benefits were negated by the harms.[3] The authors say that based on one large trial (HOT), aspirin over five years reduced myocardial infarction (number needed to treat 200) but increased major haemorrhage (number needed to harm 154). That looks like net harm to me.

Aspirin is not licensed for primary prevention of cardiovascular disease. A recent review in *DTB* concluded that low dose aspirin prophylaxis should not be routinely initiated for primary prevention, and that in those already taking it the decision about whether to continue should be taken by the patient and a healthcare professional in light of the available evidence. This should also include people buying aspirin over the counter for primary prevention.[4]

Another recent RCT of aspirin for primary prevention of cardiovascular events studied 28 980 men and women aged 50-75 years in central Scotland.[5] After a mean follow-up of 8.2 years there was no reduction in vascular events.

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Competing interests: PDB is on the editorial board of *DTB*.

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GPs left in a quandary

The recent BHS statement leaves general practitioners (GPs) with a dilemma of what to do with patients who are currently taking low dose aspirin for the primary prevention of cardiovascular disease.[1]

Most will have hypertension or diabetes, or both. They will have started aspirin treatment when type 2 diabetes was considered to be a secondary preventable disease or the Framingham based risk charts calculated their 10 year coronary heart disease risk to be ›15% (CVD risk ›20%). In my practice a third of these patients are taking proton pump inhibitors, which will prevent most upper gastrointestinal bleeding and positively affect the benefit to risk ratio. Should they be?

Also in my practice about a quarter of these patients smoke, and meta-analysis suggests that smoking negates the beneficial aspects of aspirin treatment. Should I therefore stop aspirin in this group?

Most of the beneficial effects of aspirin are by reducing non-fatal myocardial infarction.[2] As up to half of ischaemic heart disease first presents as myocardial infarction, does primary prevention with aspirin start thrombolysis early in any such cardiovascular event? Is the size of the infarct smaller if the patient is taking aspirin?

The possible "other" health advantages of low dose aspirin treatment are not considered. Low dose aspirin may prevent the development of colorectal or certain oesophageal cancers by between 20% and 60%.[3] Should GPs factor this into their calculations?

GPs need clearer answers to these questions to make evidence based decisions. They must remember also that the absolute risk reduction in using aspirin is small, with a number needed to treat of 166 patients for 10 years to prevent one significant cardiovascular event.[2]

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LONG TERM CARE

Does care at home mean no care?

Lister maintains that care at home is a good thing.[1] It is, if it actually means care. Many severely disabled people who live at home have a care package that leaves them alone for most of a 24 hour period.

Suppose someone has carers to get them up and washed, prepare lunch and dinner, and put them back to bed. This is a high level package, yet at most it represents four hours of contact. Some of my clients are confined to their bedroom, and many are put back to bed at 6 pm to spend a boring evening and night. Employing a live-in carer is fraught with difficulties, and the disruption caused by carers being off sick can be substantial and distressing. This is not care as I would like to see it. A nursing home resident can have 24 hour contact (which they can ignore if they wish), and assuming the home is good, I know which option I would prefer.

Currently, an unacceptable number of people live in isolation because of disability. Many relatives who care for disabled people are denied help because they provide care themselves; this may become intolerable, and family breakdown is not uncommon if the carer cannot cope. Sadly the standards that Lister, and many of us, would like are unaffordable, so we should not blindly accept the mantra of, "home care good, institutional care bad." Institutional care may offer real and attractive opportunities to patients with severe disability, young and old.

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DATA INTEGRITY

Everybody's responsibility

Shafer suggests that one solution to authors losing their data is to make one author (the archival author) responsible for safeguarding the integrity of raw data.[1]

There is a better way. We have made considerable strides in improving transparency in research through disclosure in trial registries. Part of that effort relates to the deposition of results.[2] It would be in the public interest if all journals were to require authors submitting manuscripts to also deposit their raw data in a repository. This would prevent accidental loss of data, ensure verifiability, allow for reanalysis when appropriate, and protect authors against suggestions of breaches of research integrity.

The question of who owns data is often asked. Research data belong to everyone. Data integrity is a matter for public concern and for collective action to restore public confidence.[3] Organisations such as the International Committee of Medical Journal Editors (ICMJE) and Committee on Publication Ethics (COPE) would do well to consider this a moral duty.

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